

ARTICLE

EMTALA and COVID-19: What You Need to Know During the Pandemic

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As part of our COVID-19 blog series, on March 17, 2020 we covered a host of regulatory and accreditation issues that arose as survey agencies reacted to COVID-19. In this post we will dig a little deeper into implications for EMTALA during the pandemic.

EMTALA and COVID-19

A CMS memorandum to State Agencies issued on March 9th, 2020 ([QSO-20-15-Hospital/CAH/EMTALA](#)) explored the nuances of the Emergency Medical Treatment and Labor Act (EMTALA) compliance during the pandemic, including the possibility of “EMTALA / 1135 waivers.”

With our decades of experience helping hospitals and health systems develop solutions for adverse EMTALA findings, we offer some practical advice as hospitals across the country cope with the projected onslaught of patients with respiratory illnesses.

Keep in mind that patients with the usual array of urgent / emergent conditions will continue to arrive at your doorstep. So, how do you cope with these patients on top of a significant increase in the number of patients with respiratory complaints while complying with EMTALA? Read on.

Applicability

EMTALA applies to all hospitals and critical access hospitals, including freestanding psychiatric hospitals. It does not apply to freestanding, off-campus outpatient clinics of the hospital unless the clinic provides or advertises unscheduled emergency services. So, when we refer to “hospitals” within this post, we’re also talking about critical access hospitals, freestanding psychiatric hospitals, and freestanding emergency departments that are part of the hospital’s CCN.

EMTALA Enforcement is Retrospective

There are no “routine” EMTALA surveys. All surveys validating compliance with EMTALA are triggered when the CMS Regional Office receives notification of a potential violation: a family gets turned away from the ED or Labor and Delivery; the patient leaves before the conclusion of care after waiting a long time; a nearby hospital receives what it perceives to be a “dump” from your organization, etc.

To ensure you remain compliant, stay apprised of the following:

- be aware of your ED wait times, especially for ESI 2 patients;
- be careful about how you direct patients to go alternate locations for screening (see below); and
- make sure to document well.

Regulators are very understanding during the COVID-19 crisis. However, the care and service you give today will be subject to review after the pandemic is behind us.

What if you don't have a "Dedicated Emergency Department?"

Locations called "The Emergency Department" or similar terms are, indeed, Dedicated Emergency Departments. But so are triage areas of Labor and Delivery units and most walk-in/drive-in psychiatric screening units that are part of freestanding acute psychiatric hospitals.

Does that mean psychiatric hospitals or perinatal units need to treat all medical illnesses? No. It merely means that they are obliged to stabilize emergently ill patients until they can arrange for their transfer to the appropriate location. This also means that these units need to be able to recognize patients requiring care beyond their capability.

Even if the hospital doesn't have anything that looks like an emergency department, it still has EMTALA obligations. All hospitals must have a process to identify, stabilize, and arrange for the care of anyone who appears to be experiencing a medical emergency. That typically looks like a nurse who is called to see the patient and summon 911 if (s)he believes it is warranted by the patient's condition.

Special Considerations During COVID-19

CMS's March 9 memo is 17 pages long, so it contains *a lot* of information. Most of it is common sense, but the following are a few highlights.

- All (all) Dedicated Emergency Departments must be prepared to apply an evidence-based (e.g. CDC, state or local department of public health) guideline to screen for patients requiring hospitalization or other potentially life-or-limb-saving care. Once identified, these patients should be stabilized by the hospital or transferred elsewhere for stabilization if indicated by the patient's condition.
- Hospitals have no choice but to accept higher-level-of-care transfer requests if they have the current capability and capacity to care for the patient. When considering whether you have the current capacity and capability to care for the patient, remember that CDC does not currently require a negative pressure respiratory isolation room (an AIIR or Airborne Infection Isolation Room) for COVID-19 patients, although AIIRs are recommended for aerosol-producing procedures. Be sure to document the reason why should you need to refuse an inbound higher-level-of-care transfer request.
- The hospital must be able to implement appropriate transmission-based precautions for suspected or verified COVID-19 CMS demurs to CDC with respect to "isolation" when ideal personal protective equipment and settings for precautions are not available.
- The hospital may redirect patients to a location for the screening and treatment of patients with respiratory complaints that is separate from the emergency department. If they do so, EMTALA requires that this alternate site be on the hospital campus (unless the hospital has an EMTALA Waiver — see below) and that the separation of respiratory and other emergency patients does not present a barrier to emergency medical screening and stabilization.
- Signs may be placed to direct respiratory patients to this alternate location. They may even be in or at the entrance to the emergency department. But they cannot have the effect of denying or discouraging emergency care.

- A staff member may be stationed to help patients find the correct venue for their complaint. However, this staff member must be clinically competent to recognize outward signs or complaints that indicate the need for immediate treatment. CMS implies this should be a registered nurse, but there may be other alternatives in times of staff shortage.
- Patients may be directed to an alternate on-campus screening site after they've checked in at the Emergency Department.
- Although hospitals may set up off-site locations under their CCN for patients with respiratory illnesses, they cannot direct patients who have already come to the hospital emergency department until they've completed a medical screening examination on the patient.
- Signs can assist the patient find the right location before they present to the emergency department.
- Although CMS does not mention this, EMTALA does not prohibit the hospital informing patients of community based COVID-19 screening locations that are not part of the hospital.
 - This information can be on carefully worded signs, flyers at the reception desk in the lobby and so forth. However, there is a fine line between informing the patient of alternative non-hospital sites in the community and discouraging the patient from seeking care at the hospital.
 - Informing the patient is allowed, even encouraged.
 - Discouraging patients from seeking hospital care is prohibited.
 - The difference between “informing” and “discouraging” is in the eye of the beholder.

- Once the patient arrives at the ED, however, the hospital is obliged to screen and, when necessary, stabilize (meaning having a valid aftercare plan if the patient does not require further hospital care).
- CMS indicates that registered nurses may perform the complete EMTALA medical screening examination if they are trained to do so and the practice is allowed by state law. The hospital may consider this approach, but remember that a “medical screening examination” is more than simple triage. Whereas the RN-assigned Emergency Severity Index (ESI) is a great and commonly used triage guideline, assigning an ESI score does not satisfy EMTALA’s medical screening requirement. We generally advise against using registered nurse to perform the EMTALA screening examination (unless, of course, they are advanced practice nurses). However, if you find it necessary to do so, make sure the RN-based examination is firmly based on criteria and medical screening algorithms approved by emergency medicine. It will be important to document the approval of these guidelines, have evidence of the extra RN training, and to monitor closely how well the RNs are adhering to the guidelines. A missed diagnosis by a registered nurse will be scrutinized far more than a similar finding made by a physician or extended role practitioner (PA, RNP).

EMTALA Waivers

A waiver is possible if the hospital finds that the bounds imposed by EMTALA are not workable during the pandemic. EMTALA can waive the prohibition against directing individuals to off-campus hospital clinics for screening and for the transfer of certain unstable patients. There are several hoops to jump through if a hospital wishes to request such a waiver, but the EMTALA waiver window is now or should soon be open.

Conclusion

EMTALA is a very complex and high-risk subject. The intent of this post is not to provide specific consultation based on your exact situation, but to answer common questions and to stimulate thinking. Don't mistake these words for legal advice. Such legal advice can only be provided by an attorney based on a case-specific situation.

So, as you work with your community, state and federal experts to provide essential care to the community in this time of crisis, be assured that there is almost always an EMTALA-compliant way to do exactly what you need to do. Just stay focused on the patient and let us or someone else with deep EMTALA expertise and experience help with the bureaucracy.

LEARN MORE ABOUT THE AUTHOR



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